

Client Assistance Program  
2401 NW 23rd, Ste 90, Oklahoma City, OK 73107

**RELEASE OF INFORMATION (Please print clearly)**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

TO WHOM IT MAY CONCERN:

I have requested services from the State of Oklahoma Client Assistance Program (CAP). In connection with such services I do hereby:

1. Authorize and request any person, school, physician, clinic, hospital or agency to furnish to CAP full and accurate social, education, psychiatric, and medical documentation of any subject regarding myself and/or any other information that might be helpful to CAP;
2. Acknowledge that this authorization includes my confidential medical records;
3. Release any person, school, physician, hospital, or agency from any liability for furnishing information pursuant to this *Release of Information*; and
4. Authorize appropriate U.S. Government officials to review the contents of my CAP files including information released pursuant to this *Release of Information*. Such review is to monitor CAP's compliance with federal statutes. Such officials may not disclose any personally identifiable information observed in such review.

I understand that I am not required to use the Client Assistance Program to dispute any actions affecting my rehabilitation program or appeal a decision of the Department of Rehabilitation Services staff. My options also include representing myself, asking a friend or family member to act as my representative or hiring legal counsel at my own expense.

Copies of this form and signature are to be considered as valid as the original. This release is valid for one (1) year from the date below and can be canceled upon my written request to CAP at any time.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_

Dated: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

**Contact Data:**

Are you a current Rehabilitation Services client? YES/NO

Name:

Date/time of call:

Mailing Address:

Phone:

Alt Phone:

Fax:

Email:

**The information listed below is required by Federal reporting requirements and will be included in the CAP annual report. Your personal information will not be a part of this report.**

**227 Reporting Data** (required for annual report):

**Age range:** (16-21) (22-40) (41-64) (65<)

**Primary disabling condition of individual served:** (Multiple responses **are not** permitted.)

1. Blindness (both eyes)
2. Other visual impairments
3. Deafness
4. Hard of hearing
5. Deaf-blind
6. Orthopedic impairments
7. Absence of extremities
8. Mental illness
9. Substance abuse (alcohol or drugs)
10. Mental retardation
11. Specific learning disabilities (SLD)
12. Neurological disorders
13. Respiratory disorders
14. Heart and other circulatory conditions
15. Digestive disorders
16. Genitourinary conditions
17. Speech impairments
18. AIDS/HIV positive
19. Traumatic brain injury (TBI)
20. All other disabilities
21. Disabilities not known

**Ethnicity/Race:** (Multiple responses **are** permitted.)

1. American Indian or Alaskan Native (List Tribe if known)
2. Asian
3. Native Hawaiian or Other Pacific Islander
4. Black or African American
5. Hispanic or Latino
6. White
7. Race/ethnicity unknown

**Gender:**

Do you have a copy of your Individualized Plan of Employment (IPE or the PLAN)? YES / NO

**Nature of Complaint:**

ADA Title I

Vocational Rehabilitation Issue (describe):

Services delayed or denied?

Have you received a letter denying services or identifying a closure date?

Have you started an appeal of the denial?

Do you want CAP to represent you? YES/NO

**— Case information (after ROI received) —**

Counselor Name:

Counselor phone:

Counselor email

Case number (or SSAN):

Date of birth